

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00673

687

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Kent	MARYLAND	STATE Maryland	COUNTY Kent
CITY (If outside corporate limits, write RURAL OR and give nearest town) 37 TOWN Chestertown	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Chestertown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 72 Kent & Queen Anne Hospital	STREET ADDRESS (If rural give location) Rural - Fairlee		
3. NAME OF DECEASED: (First) (Middle) (Last) Stanley Lee Bald		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 24 1956	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: July 1, 1890
9. AGE last birthday: 65 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Watchman	
11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: William Bald		14. MOTHER'S MAIDEN NAME: Susan Lee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-I4-8386	
17. INFORMANT & ADDRESS: Mrs. Sarah Bald		Chestertown, Md. R.F.D.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 163X			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Brain tumor (metastasis from lung)			4 months
(B) Carcinoma of lung			2 years
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: May, 1955		19B. MAJOR FINDINGS OF OPERATION: Carcinoma of lung, left (removal of lung)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY: Home, farm, factory, street, office bldg., etc.	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 1955 to Jan. 24, 1956 , that I last saw the deceased alive on Jan. 23, 1956 , and that death occurred at 3³⁰ A.M. from the causes and on the date stated above.			
SIGNATURE Willard F. Smith		DATE SIGNED Jan. 24 1956	
ADDRESS M.D. Rock Hall, Md.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 27, 1956	
NAME OF CEMETERY OR CREMATORY Chester Cemetery		LOCATION (City, town, or county) (State) Chestertown, Md.	
DATE REC'D BY LOCAL REGISTRAR Jan. 25/1956		REGISTRAR'S SIGNATURE Clara S. Barnes	
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	

BUREAU V. F.

JAN 30 1956

RECEIVED

688

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>37</u> <u>Chestertown</u>		LENGTH OF STAY (In this place) <u>1</u> <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>37</u> <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72</u> <u>Kent & Queen Anne</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>400 Calvert St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Leon Raymond Black</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>I/18/56</u> <u>19</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>6/17/1907</u>	9. AGE last birthday <u>48</u> yrs.	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Various</u>		11. BIRTHPLACE (State or foreign country): <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>	
13. FATHER'S NAME: <u>Asbury Black</u>				14. MOTHER'S MAIDEN NAME: <u>Linda Rasin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-16-5203</u>		17. INFORMANT & ADDRESS: <u>Chestertown, Md.</u> <u>Wife Elizabeth Black</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary Thrombosis</u>						<u>one hour</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary insufficiency</u>						<u>4-5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/18</u> , 19 <u>56</u> to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>4:00</u> AM, from the causes and on the date stated above. SIGNATURE <u>Robert W. Jan</u> ADDRESS <u>Chestertown, Md.</u> DATE SIGNED <u>Jan. 18, 1956</u> M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>I/21/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fairlee (col.) Cem.</u>		LOCATION (City, town, or county) (State) <u>Fairlee - Kent Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 19-1956</u>		REGISTRAR'S SIGNATURE <u>Clara B. Barnes</u>		24. FUNERAL DIRECTOR <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECLARATION OF DEATH

JAN 23 1956

BUREAU V. 8

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

699

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00675

Reg. Dist. No. 200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		STATE <u>M.D.</u>		COUNTY <u>KENT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARY WILSON BRAMBLE</u>				<u>JAN. 21 1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 2, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELDRIDGE A. WILSON</u>				14. MOTHER'S MAIDEN NAME <u>ISABELLE HARRINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>HERMAN BRAMBLE - MILLINGTON MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Edema of the lung.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days -</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Pneumonia.</u>				<u>9 days -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Degeneration of heart muscle.</u>				<u>2.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>				<u>years.</u>			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 12, 1956</u> , to <u>Jan 21, 1956</u> ; that I last saw the deceased alive on <u>Jan 20, 1956</u> , and that death occurred at <u>12:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edw. Fellows</u> M.D.				DATE SIGNED <u>1-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1/24/56</u>		NAME OF CEMETERY OR CREMATORY <u>MILLINGTON CEM.</u>		LOCATION (City, town, or county) (State) <u>MILLINGTON KENT Co, MD</u>	
24. REC'D BY REGISTRAR <u>1/23/56</u>		REGISTRAR'S SIGNATURE <u>Edward Fellows</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		ADDRESS <u>Millington Md</u>	

BUREAU V. S.

JAN 25 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00676

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL WORTON</u>		LENGTH OF STAY (in this place) <u>LIFE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL WORTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>—</u>			
3. NAME OF DECEASED (Type or Print) <u>HARPER</u> (First) <u>RASIN</u> (Middle) <u>CARTER</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 15,</u> 19 <u>56</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 27, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WILLIAM D. CARTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY RASIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-26-2800</u>		17. INFORMANT & ADDRESS <u>DONALD K. CARTER WORTON, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>454X IMMEDIATE CAUSE (A) Thrombosis of Coronial Artery.</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Thrombosis of Coronial Artery.</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 9, 1956</u> , to <u>Jan 14, 1956</u> , that I last saw the deceased alive on <u>Jan 14, 1956</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above. SIGNATURE <u>L. P. Atwell</u> M. D. <u>Still Pond Md.</u> DATE SIGNED <u>1-15-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 19 1956</u>		NAME OF CEMETERY OR CREMATORY <u>SHREWSBURY CEMTY</u>		LOCATION (City, town, or county) (State) <u>KENNEDYVILLE, MD.</u>	
24. REC'D BY REGISTRAR DATE <u>1/17/56</u>		REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	

BUREAU V. 1

JAN 19 1956

RECEIVED

WITKIN, J. H. 1956

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD	
CERTIFICATE OF DEATH	
Name of Deceased: WILLIAM D CARTER	
Sex: MALE	
Race: WHITE	
Date of Birth: DEC 27 1884	
Place of Birth: WYOMING	
Occupation: FARMER	
Cause of Death: HEART DISEASE	
Date of Death: JAN 12 1956	
Place of Death: WYOMING	
Signature of Physician: W. H. WITKIN	
Signature of Coroner: W. H. WITKIN	
Signature of Registrar: W. H. WITKIN	

RECEIVED
JAN 19 1956
BUREAU V. 1
WITKIN, J. H. 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>KENT</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>KENT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CRUMPTON</u>				TOWN <u>CRUMPTON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ELWOOD</u> (Middle) <u>F.</u> (Last) <u>COLEMAN</u>				(Month) <u>JAN.</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>W.</u>		<u>8-18-1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Contractor</u>				<u>MARYLAND</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY COLEMAN</u>				<u>NEAL FENNIMORE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>214-34-6039</u>		<u>MRS. COLEMAN - CRUMPTON</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177x IMMEDIATE CAUSE (A) <u>Carcinoma of Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>MD</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Urolithiasis & prostate & blood & bone</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cachexia</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General Cachexia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>1952</u>		<u>Carcinoma of Prostate</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>MD</u>							
22. I hereby certify that I attended the deceased from <u>Jan 26, 1956</u> , to <u>Jan 27, 1956</u> , that I last saw the deceased alive on <u>Jan 26, 1956</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>@ H. H. H. H. H.</u>				ADDRESS (Street, city, town, state) <u>Rockersville, MD.</u>		DATE SIGNED <u>1/29/56</u>	
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>JAN 30</u>		<u>CRUMPTON</u>		<u>CRUMPTON MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan 30 1956</u>		<u>Edmund Bellows</u>		<u>EDGAR L. LANE</u>		<u>CHURCH HILL MD.</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

FILE NO. 10

NAME OF DECEASED

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CITY

COUNTY

STATE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

FINAL

OTHER

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

BUREAU V. E.

FEB 3 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00679

Reg. Dist. No. 203

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Kent		STATE Maryland		COUNTY Kent			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rock Hall				TOWN Rock Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Maragrete (Middle) E. (Last) Coleman				(Month) Jan. (Day) 6 (Year) 19 56			
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 5-1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Graff				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 214-34-7224		17. INFORMANT & ADDRESS Margaret Dashiell--Rock Hall, Md			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) Carcinoma of pancreas						18 months or longer	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
260X (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Diabetes mellitus						at least 2 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 6, 1956 , to Jan. 6, 1956 , that I last saw the deceased alive on Jan. 6, 1956 , and that death occurred at 4 P. M, from the causes and on the date stated above.							
SIGNATURE Willard F. Smith M.D.				ADDRESS (Street, city, town, state) Rock Hall, Md.		DATE SIGNED 1/9/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Jan. 9		NAME OF CEMETERY OR CREMATORY Wesley Chapel		LOCATION (City, town, or county) (State) Rock Hall, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE S. Elwood Burgess		25. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
DATE Jan 6/56							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

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BUREAU V. S.

JAN 12 1956

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INSTRUCTIONS

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

689

CERTIFICATE OF DEATH

00680

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>MARYLAND</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	
CITY OR TOWN <u>Chestertown</u>		LENGTH OF STAY (in this place) <u>3 months</u>		TOWN <u>Chestertown</u>		TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>423 High Street</u>		STREET ADDRESS (If rural give location) <u>423 High St.</u>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Benjamin Hopper Cosden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 30 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Dec. 27, 1876</u>	
9. AGE last birthday <u>79</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grain buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Cosden</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Maria Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-6569</u>		17. INFORMANT & ADDRESS <u>Mrs. Catherine Short, Ridgely Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
415X IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary atherosclerosis</u>				<u>17 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis of rheumatic origin</u>				<u>Over 17 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 10, 1939</u>, to <u>Jan. 30, 1956</u>, that I last saw the deceased alive on <u>Jan. 28, 1956</u>, and that death occurred at <u>10:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ac Bicks</u>				ADDRESS (Street, city, town, state) <u>Chestertown, Md.</u>			
DATE THEREOF <u>Feb. 2, 1956</u>				DATE SIGNED <u>1-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>			
24. REC'D BY REGISTRAR <u>Jan. 30 1956</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chestertown, Md.</u>	

CERTIFICATE OF DEATH

Reg. No. 111

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

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BUREAU V. S.

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INSTRUCTIONS

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VS AISC 1-55 10M

690

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00678

CERTIFICATE OF DEATH

Reg. Dist. No. J.02

Items 3, 13 FilmG192 2-15-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN <u>Chestertown</u>		10 minutes		TOWN <u>Rock Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
72 <u>Kent & Queen Anne's Hospital</u>							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Wilmur Charles CROUCH</u>				<u>JAN 30 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE (MARRIED) WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>MALE</u>	<u>White</u>		<u>Dec 18 1898</u>	<u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Lincoln Room</u>		<u>Chester</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Wesley Crouch</u>				<u>Grace Blackistoun</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Charles Crouch - Rock Hall.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE (A) <u>Right lobar Pneumonia</u>						<u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Emphysema</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Possible Carcinoma of lung</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Probably right sided Failure</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 28</u> , 19 <u>56</u> , to <u>Jan 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>56</u> , and that death occurred at <u>11/31/56</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Solon</u>				ADDRESS (Street, city, town, state) <u>Chestertown Maryland</u>			
DATE SIGNED <u>1/31/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>FEB 2</u>		<u>WESLEY CHAPEL</u>		<u>Rock Hall MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Feb. 4-1956</u>		<u>Clara S. Barnes.</u>		<u>Edgar L. Lane</u>		<u>Church Hill</u>	
						<u>and.</u>	

10053

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

CERTIFICATE OF DEATH

A. PLACE WHERE DEATH OCCURRED

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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BALTIMORE, MARYLAND
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BUREAU V. S.

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INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

691

CERTIFICATE OF DEATH

00681

Item 9, Film G191 1-12-56 et

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>MARYLAND</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Millington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		STREET ADDRESS		(If rural give location)	
TOWN <u>Chestertown</u>		<u>5 days</u>		<u>1122</u>		<u>1122</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent County Jail</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1122</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Gilberta Lula Everett</u>				<u>JAN. 1 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>8-2-16</u>	<u>39 3/4</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Alfred Robinson</u>				<u>Lizzie Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Hsp. Records</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
593X IMMEDIATE CAUSE (A) <u>Cerebral apoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>30 hours</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Nephritis</u>						<u>Several years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bleeding gastric ulcer</u>						<u>Several years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>12-31-55</u>		<u>Bleeding gastric ulcers</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-28</u> , 19 <u>55</u> , to <u>1-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-1</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Al Dick</u>				ADDRESS (Street, city, town, state) <u>Chesapeake Md</u>		DATE SIGNED <u>1-2-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>1/4/56</u>		<u>Crumpton Cem.</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Jan. 4-1956</u>				<u>Clara S. Barnes</u>		<u>Edward Fellows-Millington Md.</u>	
DATE				ADDRESS			

BUREAU V. S.

JAN 9 1956

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JAN 9 1966

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CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Worton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Kent & Queen Anne's Hospital</u>				STREET ADDRESS (If rural give location) <u>RR #1</u>		1	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Harris</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 17 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1-16-56</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	<u>8 55</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Benjamin Harris</u>				14. MOTHER'S MAIDEN NAME: <u>Joyce Deborah Brooks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>RR #1, Worton Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Unknown -</u>						1 <u>hour</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Premature birth 26-28 weeks</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16</u> , 19 <u>55</u> , to <u>1-17</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1-17</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Jones</u>		ADDRESS <u>Chestertown, Md</u>		DATE SIGNED <u>1-17-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>SHARPTOWN CEMT</u>		LOCATION (City, town, or county) (State) <u>ROCK HALL, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/17/56</u>		REGISTRAR'S SIGNATURE <u>E. Kennard Jones</u>		24. FUNERAL DIRECTOR <u>Victor N. Kennedy</u>		ADDRESS <u>STILL POND, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 14 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Kent</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
<u>X</u> TOWN <u>Fairlee</u>	<u>life</u>	TOWN <u>Chestertown</u>	<u>37</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>70</u> <u>Strong Nursing Home</u> <u>Chestertown R.F.D.</u>		<u>Cannon # 418</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH	
(First) (Middle) (Last)			
<u>Mary</u> <u>Emma</u> <u>Hirons</u>		<u>Jan. 28, 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>Widowed</u>	<u>Oct. 21, 1864</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>91</u> yrs.	Months	Days	Hours
			Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
<u>Housewife</u>			<u>Kent Co. Maryland</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>George B. McWhorter</u>		<u>Lydia Barton Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>no</u>	
17. INFORMANT & ADDRESS:			
<u>Bradford Hirons</u>		<u>Chestertown Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
450.1 IMMEDIATE CAUSE (A) <u>Toxemia</u>			<u>1 wk</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Consequence of left leg</u>			<u>2 wk</u>
(C) <u>Arteriosclerosis</u>			<u>year</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Right Sided Heart Failure</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 10</u> , 19 <u>56</u> , to <u>Jan 28</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan 25</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Thomas J. Tolson</u>		<u>226 W. Main and Chestertown, Md. 1/30/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Chester Cem.</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>Jan. 30-1956</u>		<u>Chestertown, Md.</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Clara L. Barnes</u>		<u>J. Willis Wells - Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 1 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

693

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00684

CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural, Crumpton 17X-2</u>			
37 TOWN <u>Chesapeake</u>				STREET ADDRESS (If rural give location) <u>Pond town</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kentwood Queen Anne's Hosp.</u>				72			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last) <u>EMMA M. HONEY</u>				OF DEATH: <u>Jan. 9 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 15, 1877</u>	
9. AGE last birthday <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days Hours Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William S. Elliott</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Elizabeth Elborn</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Hosp. Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE				(A) <u>Myocardial insufficiency</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Atherosclerosis</u>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Tangrene both lower legs due to arteriosclerosis + frost bite</u>							
19A. DATE OF OPERATION: <u>1-9-56</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Tangrene of both lower legs - arteriosclerosis.</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-30-55</u> , to <u>1-9-56</u> , that I last saw the deceased alive on <u>1-9-56</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS <u>Chesapeake, Md.</u>		DATE SIGNED <u>1-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 12, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cem.</u>		LOCATION (City, town, or county) (State) <u>Pondtown Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/11/56</u>		REGISTRAR'S SIGNATURE <u>Edward Fellows</u>		24. FUNERAL DIRECTOR <u>Edward Fellows</u>		ADDRESS <u>Wellington, Md.</u>	

BUREAU V. S.

RECEIVED

694

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Kent</u>	MARYLAND	STATE	COUNTY <u>Kent</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>37 Chester Town</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Millington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Kent + Queen's Hosp.</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Baby Johnson</u>		OF DEATH: <u>1</u> <u>2</u> <u>1956</u>	
5. SEX: <u>7.</u>	6. COLOR OR RACE: <u>Chad</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>1-1-56</u> <u>3:08 AM</u>
		9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY: <u>Baby</u>	11. BIRTHPLACE (State or foreign country): <u>md.</u>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME: <u>Reginald Arnold Johnson</u>	14. MOTHER'S MAIDEN NAME: <u>Violet Mae Jeffers</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: <u>Reginald Arnold Johnson - Millington Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>776X Premature Baby</u>	DUE TO	<u>4 hrs.</u>
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from <u>1/1</u> , 19 <u>56</u> to <u>1/2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.	
SIGNATURE <u>Sharon J. Solon</u>	DATE SIGNED <u>Jan. 4/1956</u>

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan. 4/1956</u>	<u>St. Pleasant</u>	<u>Portsmouth Md.</u>

DATE REC'D BY LOCAL REGISTRAR <u>Jan. 3-1956</u>	REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	24. FUNERAL DIRECTOR <u>Edward Villanueva</u>	ADDRESS <u>Millington Md.</u>
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 5 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00686

704
CERTIFICATE OF DEATHReg. Dist. No. 2-03

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		STATE <u>Maryland</u> COUNTY <u>Kent</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rock Hall</u>		TOWN <u>Rock Hall</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>George W. Kendall</u>				<u>Jan. 4 19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>May 5- 1871</u>	9. AGE last birthday <u>about 84</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. W. McClary--Rock Hall, Md.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO <u>arteriosclerosis</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>56</u> , to <u>Jan 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>56</u> , and that death occurred at <u>12 noon</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. Kasper</u>				ADDRESS (Street, city, town, state) <u>Rock Hall 1/6/56 md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 6</u>		NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		LOCATION (City, town, or county) (State) <u>Rock Hall, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>J. S. Kasper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill, Md.</u>	
DATE <u>Jan 6-1956</u>							

CERTIFICATE OF DEATH

T-1

Reg. No. 219

1. DECEASED'S NAME - LAST, FIRST, MIDDLE

MARYLAND

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. MARRIAGE

11. EDUCATION

12. RELIGION

13. SERVICE

14. MANNER OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESSES

18. SIGNATURE OF DECEASED

19. SIGNATURE OF NEXT OF KIN

20. SIGNATURE OF CLERGYMAN

21. SIGNATURE OF BURIAL OFFICIAL

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF CORONER

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CLERK

28. SIGNATURE OF RECORDER

29. SIGNATURE OF INDEXER

30. SIGNATURE OF FILE CLERK

BUREAU V. S.

JAN 11 1956

RECEIVED

DECEASED'S NAME

DECEASED'S NAME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

695

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Chestertown</u>		<u>life</u>		TOWN <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cannon St. Ext.</u>				STREET ADDRESS (If rural give location) <u>Cannon St. Ext.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Patricia Ann Lewis</u>				OF DEATH: <u>I/II/1956</u> <u>19</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>single</u>	<u>3/28/1951</u>	<u>4</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Chestertown, Md.</u>	
13. FATHER'S NAME: <u>Elridge Lewis</u>				14. MOTHER'S MAIDEN NAME: <u>Helen Lins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Chestertown, Md. Cannon St. Ext.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute enteritis - bacterial cultures sent but not reported</u>							<u>2 days</u>
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 11, 1956</u> , to <u>Jan 11, 1956</u> , that I last saw the deceased alive on <u>Jan 11, 1956</u> , and that death occurred at <u>5:30P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert W. Farr</u>				ADDRESS <u>M. O. Chestertown, Md.</u> DATE SIGNED <u>Jan. 12, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 14, 1956</u>		<u>Chester Cem.</u>		<u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 13-1956</u>		<u>Clara S. Barnes</u>		<u>J. Willis Wells</u>		<u>- Chestertown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

BUREAU V. S.

JAN 16 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00688

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>Worton</u>		<u>life</u>		<u>Worton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Ernest Hicks Loller</u>				<u>JAN 25 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>male</u>	<u>white</u>	<u>Married</u>	<u>Sept. 7, 1882</u>	<u>73</u> yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>owner</u>		<u>Kent Co. Md.</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Daniel Loller</u>				<u>Ella Hicks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>no</u>				<u>YES</u>			
17. INFORMANT & ADDRESS:				<u>Worton, Md.</u>			
				<u>Mrs. Bertha Skeggs Loller</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Thrombosis of Carotid Artery.</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Paralysis agitans</u>						<u>5 days</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 20, 1956</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 23, 1956</u> , and that death occurred at <u>5 A M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>L. P. Altwie</u>		<u>Slieve Pond Md</u>		<u>1-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/27/1956</u>		<u>Chester Cemetery</u>		<u>Chestertown, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 25-1956</u>		<u>Clara S. Barnes</u>		<u>J. Willis Wells</u>		<u>Chestertown, Md.</u>	

DECLARATION OF DEATH

BUREAU V. 2

JAN 30 1956

RECEIVED

696

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Queen Anne's Co</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>New Jersey</u> COUNTY <u>Middlesex</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chester Town, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sayreville</u> <u>678-13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kept at Queen's Anne's Hosp</u>		STREET ADDRESS (If rural, give location) <u>41 Bennett St N.J.</u>	
3. NAME OF DECEASED (Type or Print) <u>Eleanor</u> (First) (Middle) (Last) <u>McCutcheon</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 25</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4/31/1900</u>
9. AGE last birthday <u>55</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Phila., Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Miller</u>	
14. MOTHER'S MAIDEN NAME <u>Lena Taylor</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>156-03-7326</u>		17. INFORMANT AND ADDRESS <u>Wm. McCutcheon</u> <u>34 Outlook Ave. Sayreville, N. J.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>816X</u> Immediate cause (a) <u>Auto Accident 1/24-56</u> Antecedent cause(s) (b) <u>Broken right arm cut on forehead</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>abrasions on body</u> <u>Had heart attack & died</u>			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Auto Accident - mvt to mvt</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>W. Henry Fisher M.D. Centerville Md. Deputy Med Exam for 2450 mch 1/25/56</u>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 28, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>New Calvary</u>		LOCATION (City, town, or county) (State) <u>Parlin, N. J.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 25-1956</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>	
24. FUNERAL DIRECTOR <u>W. Willis Wells</u>		ADDRESS <u>Charleston Md.</u>	

BUREAU V. S.

JAN 30 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 263

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Kent		MARYLAND		STATE Maryland		COUNTY Kent	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Rock Hall		LENGTH OF STAY (in this place) 20 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rock Hall			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
Geprge Powell				Jan. 28, 1956			
5. SEX: Male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single	8. DATE OF BIRTH: ? ? 1870	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: Laborer		11. BIRTHPLACE (State or foreign country): Phila. , Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Charles Leed Powell				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY NO. don't know		17. INFORMANT & ADDRESS: W. H. Leedom 5222 Pentridge St Phila. Penna.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary thrombosis						18 hours	
ANTECEDENT CAUSE (B) Arteriosclerosis						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1 , 19 55 to Jan 28 , 19 56 , that I last saw the deceased alive on Jan 28 , 19 56 , and that death occurred at 3 P M. from the causes and on the date stated above.							
SIGNATURE Willard F. Smith MD		M. D.		ADDRESS Rock Hall, Md		DATE SIGNED 1/28/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 1, 1956		NAME OF CEMETERY OR CREMATORY Chester Cem.		LOCATION (City, town, or county) (State) Chestertown, Md.	
DATE REC'D BY LOCAL REGISTRAR 1/30/56		REGISTRAR'S SIGNATURE J. Willis Wells		24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 2 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
37 TOWN <u>Chester Town</u>				TOWN <u>Worton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Kent + Queen Anne's Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Le Roy Scott</u>				<u>Jan 1 1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		8. DATE OF BIRTH: <u>Sept 24 1896</u>		7. AGE last birthday: <u>59</u> yrs.	
		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):				IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farming</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Scott</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Minner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-0174</u>		17. INFORMANT & ADDRESS: <u>Mrs. Le Roy Scott, Worton Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cornary thrombosis</u>		
ANTECEDENT CAUSE (S) DUE TO (B) _____		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-28, 1955, to 1/1, 1956 that I last saw the deceased alive on 12-31, 1956, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>Wick</u>		ADDRESS <u>Chester town Md</u>		DATE SIGNED <u>1-2-56</u>	
M.D. <u>Wick</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Jan. 4, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery</u>	LOCATION (City, town, or county) <u>Denton</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/3/56</u>	REGISTRAR'S SIGNATURE <u>Edmund Jones</u>	24. FUNERAL DIRECTOR <u>Victor M. Kennedy</u>	ADDRESS <u>Still Pond, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CORONARY
THROMBOSIS

BUREAU V. S.

JAN 10 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00692

707
CERTIFICATE OF DEATHReg. Dist. No. 200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millington</u>				TOWN <u>Millington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u> (Middle) <u>Lewis</u> (Last) <u>Starkey</u>				(Month) <u>Jan.</u> (Day) <u>8</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>May 3 1880</u>	<u>75</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Tenant Farmer</u>		<u>Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Starkey</u>				<u>Ellen Boyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mattie O. Starkey Millington Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Stroke</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiovascular disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Renal disease</u>						<u>unknown</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>		<u>None</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
		<u>Home</u>		<u>Home</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 3-1, 1956</u> , to <u>Jan 8, 1956</u> , that I last saw the deceased alive on <u>Jan 8, 1956</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. H. Hamilton</u>				DATE SIGNED <u>1/10/56</u>			
M.D. <u>Millington Md</u>				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 11 56</u>		<u>Millington Cemetery</u>		<u>Millington Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1/10/56</u>		<u>Edward Fellows</u>		<u>Edward Fellows</u>		<u>Millington Md</u>	

100038

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Case No.

A. DEATH REPORTED TO THE REGISTRAR

DATE OF DEATH

PLACE AND

CAUSE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

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SHORT CURSUS

On the 18th day of 1936, at Baltimore, Maryland, I, the undersigned, Registrar of the State Department of Health, do hereby certify that the above is a true and correct copy of the original record of the death of the deceased named above, as the same appears in the records of the State Department of Health, and that the same is in accordance with the laws of the State of Maryland.

Witness my hand and the seal of the State Department of Health, at Baltimore, Maryland, this 18th day of 1936.

REGISTRAR

BUREAU V. S.

APR 18 1936

RECEIVED

698

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Kent</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>37 Cheltenham</u>		LENGTH OF STAY (in this place) <u>10 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u>		OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>72 Kent & Queen Anne Hosp.</u>				STREET ADDRESS (If rural give location) <u>Cheltenham P.O. #2</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Margaret</u>		(Middle) <u>Stratton</u>		(Last) <u>Stoops</u>			
(Type or Print)				OF DEATH: <u>Jun. 8 1956</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 28, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
				Months	Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles T. Stratton</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Finnimore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No IVe</u>		17. INFORMANT & ADDRESS: <u>Mrs. Carolyn Hopkins - Cheltenham Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
527.2 IMMEDIATE CAUSE (A) <u>Respiratory Arrest.</u>						#	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Chronic Cystic Disease of the Lungs.</u>						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>with Fibrosis & Emphysema</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Congestive Heart Failure</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30, 1956</u> , to <u>1/8, 1957</u> , that I last saw the deceased alive on <u>1/8/56</u> , 1956, and that death occurred at <u>1:20 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Thomas J. Solon</u>		M. D. <u>Cheltenham Md</u>		ADDRESS <u>Cheltenham, Maryland</u>		DATE SIGNED <u>1/8/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cheltenham Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cheltenham, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 9-1956</u>		REGISTRAR'S SIGNATURE <u>Clara S. Barnes.</u>		24. FUNERAL DIRECTOR <u>Wm. V. Williams - Cheltenham Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 11 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

708

CERTIFICATE OF DEATH

00694

Reg. Dist. No. 202

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Chestertown</u>		<u>life</u>		OR TOWN <u>Chestertown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. 2</u>				STREET ADDRESS (If rural give location) <u>R.F.D. 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Janie</u> (Middle) <u>Thompson</u> (Last)				Jan. 10, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>colored</u>	<u>Married</u>	<u>Feb. 23, 1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>James s Ringgold</u>				14. MOTHER'S MAIDEN NAME <u>Sara Carroll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-22-9603</u>		17. INFORMANT & ADDRESS <u>Walter Wallace</u> <u>Chestertown, Md</u> <u>R.F.D 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
490x IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Congestive heart failure Hypertension</u>				<u>one year at least</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Mucous colitis</u>				<u>several years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 53</u> , to <u>Jan 10, 1956</u> , that I last saw the deceased alive on <u>Jan 10, 1956</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard F. Smith</u> M.D.				ADDRESS (Street, city, town, state) <u>Rock Hall, Md</u> DATE SIGNED <u>1/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/14/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Sandy Bottom</u>		LOCATION (City, town, or county) (State) <u>nr.- Chestertown, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 12-1956</u>		REGISTRAR'S SIGNATURE <u>Clara L. Barnes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>		ADDRESS <u>Chester to wn, Md.</u>	

BUREAU V. S.

AN 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

00695

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH- COUNTY <u>Kent</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Kent</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chestertown</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chestertown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.</u>				STREET ADDRESS <u>R.F.D.</u> (If rural, give location)	
3. NAME OF DECEASED (First) <u>Lucie Maria</u> (Middle) <u>Grover</u> (Last) <u>Usilton</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 9, 1874</u>	9. AGE last birthday <u>81</u> yrs.	If under 1 year If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>James Grover</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hollihan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Herbert Usilton Chestertown, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cardio Vascular - Coronary Insufficiency

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Atherosclerosis, Hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY? Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 11, 1955, to Jan 4, 1956, that I last saw the deceasedalive on Jan 3, 1956, and that death occurred at 3:29 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 5 - 1956 Clara L. BarnesJ. Willis Wells - Chestertown, Md.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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JAN 9 1956

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00696

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CERTIFICATE OF DEATH

Reg. Dist. No. 200

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Kent</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Kent</u>	
CITY OR TOWN <u>Millington</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Millington</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)		1	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>NELLIE VIOLA WILSON</u>				Jan. 14, 1956			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Feb. 7, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME <u>Edward Sampson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Garrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>220-01-3242</u>		17. INFORMANT & ADDRESS <u>Slater Wilson Millington md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
434.3 IMMEDIATE CAUSE (A) <u>Syncope of the heart.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>suddenly</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 14, 1956, to Jan. 14, 1956, that I last saw the deceased alive on Jan. 14, 1956, and that death occurred at 2:30 PM, from the causes and on the date stated above.							
SIGNATURE <u>Edwards Holloway</u>				DATE SIGNED <u>1-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Jan 18/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mountain Mc. Cem.</u>		LOCATION (City, town, or county) (State) <u>Rural Lynch md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Edward Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Holloway</u>		ADDRESS <u>Millington md</u>	
DATE <u>1/16/56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

THE UNIVERSITY OF CHICAGO PRESS

U. S. BUREAU

6561 ST NYC

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